WATSON CLINIC LLP

Quality Healthcare for Every Generation

PATIENT INSTRUCTIONS:
Please complete the top portion of this form and provide it to your Ophthalmology / Optometry provider for completion.

(PLEASE PRINT)

Patient Name: _____

Date of Birth: _____ **Chart Number**: _____

To Eye Care Professional:

In an effort to improve communication regarding our diabetic patient's annual dilated retinal eye exam, we kindly ask that you complete and return this form **OR** your consultation form to Watson Clinic LLP via FAX to 1-866-426-2690.

We thank you in advance for your assistance in maintaining the health of our shared patients.

The above patient has been seen in my office for a retinal exam on _____ (DATE)
with the following findings:

- ☐ Diabetic retinopathy — Intermediate____Neg____Pos____
- ☐ Background diabetic retinopathy — OD_____OS_____OU_____
- ☐ Proliferative diabetic retinopathy — OD_____OS_____OU_____
- ☐ Dilated Fundascopic Exam performed — Yes _____No _____

Other Findings: _____

_____

_____

_____

Recommendations: ☐ Follow up visit in _____

☐ Other: _____

Please Print Physician Name _____

_____ Date _____

Signature of Ophthalmologist/Optometrist